MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 11279

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: WESTMINSTER, ROUTE 6
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ROUTE 6
(If rural, give LOCATION)

2.(a) If veteran, name war: NONE

3. (a) FULL NAME: D. ALBERT ARNOLD

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: EMMA L. ARNOLD 6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.): AUGUST 30, 1873

8. AGE: Years: 75 Months: 3 Days: If less than one day: hrs. min.

9. Birthplace: CARROLL COUNTY, MD.
(Town, county, and state)

10. Usual occupation: FARMER

11. Industry or business

FATHER
12. Name: SAMUEL G. ARNOLD
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: CAROLINE SAYLOR
15. Birthplace: MARYLAND

16. Informant: MRS. D. ALBERT ARNOLD
Address: WESTMINSTER, MD R6.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: DEC. 3, 1948 (month) (day) (year)

Cemetery or crematory: DEER PARK CEM.

Location: SMALLWOOD, MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 12/1 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOV. 30 19 48, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...

and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Acute Coronary Occlusion	1/2 hr.
Due to: Chronic Hypertension	years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: James T. Howard Deputy Medical Exam. M. D. or other

Address: ... Date signed 11/30/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

2nd CB 11280

97

Reg. Dist. No. 79

M

1. PLACE OF DEATH:
County Carroll
City or town Keymar Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Penna County
City or town Philadelphia
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Margaret R. Aurand

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: John L. Aurand
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 15, 1855

8. AGE: Years	Months	Days	If less than one day
93	8	9	..... hrs. ..... min.

9. Birthplace: Penna (Town, county, and state)
10. Usual occupation: housework
11. Industry or business
FATHER 12. Name: James Boggs
13. Birthplace: Pa
MOTHER 14. Maiden name: Martha Henryn
15. Birthplace: Pa
16. Informant: Harry L. Aurand
Address: Keymar, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 26, 1948 (month) (day) (year)
Cemetery or crematory: Keysville
Location: Keysville, Md.
18. Funeral director: C. O. FUSS & SON
Address: Taneytown, Md.
19. 11/26/ (Date rec'd by registrar) 1948 Fanny M. Powell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 24 1948, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 6 1948, to Nov 24 1948 and that I last saw her alive on Nov 22 - 1948

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other
Address: Union Bridge Date signed 11-24-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11281

FILM No. G 118 DEC - 6 1948 also Dec. 9 1948 L

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or Institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore 17, (if outside city or town limits, write RURAL and give nearest town)

Street No. 602 W. Mount Streer (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Crawford Bailey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Separated

6.(b) Name of husband or wife: Blanche Bailey

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): June 20, ~~1896~~ 1901

8. AGE: Years	Months	Days	If less than one day
47 ~~47~~ 47 ~~47~~	5	10	hrs. min.

9. Birthplace: Accomac County, Virginia (Town, county, and state)

10. Usual occupation: Pool Room Helper

11. Industry or business:

FATHER — 12. Name: John Bull

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Louise Ames

15. Birthplace: Virginia

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec-3 1948 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Brooklyn

18. Funeral director: Wm Brooks Tuggold

Address: 1637 N. Carey St

19. November 30, 19 48 (Date rec'd by registrar) Albert R. [illegible] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30, 19 48, at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 3, 19 48, to November 30, 19 48 and that I last saw h im alive on November 30, 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	August 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben H. Foman, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 11-30-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11282

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 11 months, 23 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltinore 17,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 546 W. MosherS Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William Thomas Barnett

3.(b) Social Security Number: 212-20-4556

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Etta Barnett

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): February 28, 1882

8. AGE: Years	Months	Days	If less than one day
66	8	27	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Night Watchman

11. Industry or business:

FATHER
12. Name: Solma Barnett
13. Birthplace: Maryland

MOTHER
14. Maiden name: Josephine Locks
15. Birthplace: Maryland

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: NOV 29 1948 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cemetery

Location: Balto. Md.

18. Funeral director: Mrs. Samuel T. Hemsley

Address: 578 W Biddle St

19. November 25, 1948 (Date rec'd by registrar) Albert R. Swankhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25, 1948 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 2, 1946 to November 25, 1948 and that I last saw him alive on November 25, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 11-25-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11283

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 7 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Samatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore 17,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1318 Fulton Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

Gloria Anne Bayton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 5, 1931

8. AGE: Years	Months	Days	If less than one day
17	9	11	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER
12. Name: Carter Bayton
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annabelle Owens
15. Birthplace: Maryland

16. Informant: Annabelle Walls
Address: 1318 Fulton Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 20, 1948 (month) (day) (year)

Cemetery or crematory: Arbutus

Location: Baltimore, Md.

18. Funeral director: Geo. S. Nelson

Address: 1303 Pennsylvania Ave.

19. November 16, 19 48 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16, 1948, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 9, 1948, to November 16, 1948 and that I last saw her alive on November 16, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	January 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 11-16-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

11284

CERTIFICATE OF DEATH

Reg. Diat. No. 80

1. PLACE OF DEATH:

County Carroll

City or town New Windsor - Uniontown road
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? accidental

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town New Windsor, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Leonard Bowers

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of ~~husband~~ or wife Mary Rodkey Bowers

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13 - 1919

8. AGE: Years 29 | Months 10 | Days 16 | If less than one day ... hrs. ... min.

9. Birthplace Carroll County, Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Rev Bernie Bowers
13. Birthplace Maryland

MOTHER
14. Maiden name Virgie Hawk
15. Birthplace Maryland

16. Informant Mrs Mary R Bowers
Address New Windsor, Md RD

17. Burial Date thereof Dec 1-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Piney Creek Brethren Cemetery

Location near Taneytown

18. Funeral director O.D. Hartsuk & Sons

Address Union Bridge & New Windsor, Md

19. Nov 29 1948 Ena D Bush
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1948, at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Drowning	
Due to Tractor upset into stream	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11-29-48

Where did injury occur? Pipe Creek New Windsor Carroll Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Pipe Creek

Means of injury Tractor upset Injured at work? Yes

23. SIGNATURE James T. Shaw, Deputy Medical Examiner
M. D. of other

Address Westminster Md Date signed 11-29-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 — Bc 11285

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore 18
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2440-Brentwood Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John Henry Brooks

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married.

6.(b) Name of husband or wife: Susie Brooks

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): November 8, 1875

8. AGE: Years	Months	Days	If less than one day
73	0	17	...hrs. ...min.

9. Birthplace: Calvert County, Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: John Parker
13. Birthplace: Calvery Count, Md.

MOTHER
14. Maiden name: Georgeanna Parker
15. Birthplace: Calvery County, Md.

16. Informant: Gladys Brooks (daughter)
Address: 2440 Brentwood Ave. Baltimore 18, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-28-48 (month) (day) (year)

Cemetery or crematory: Youngs Chapel.

Location: Calvert Co. Md.

18. Funeral director: Geo. S. Kelson

Address: 1303 Bressman. St.

19. November 25, 1948 (Date rec'd by registrar) Albert R. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 1948, at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 5, 1948, to November 25 1948 and that I last saw h... im... alive on November 25 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations: ...Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work? ...

23. SIGNATURE: Reuben Hoffman, M. D. (M. D. or other)

Address: Henryton Md. Date signed: Nov. 25, 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct page if especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d By 11286

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since October 13, 1925

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? since October 13, 1925

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: ?

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CRATE, Herman H.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	separated

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): October 24, 1872

8. AGE: Years	Months	Days	If less than one day
76	1	2	....hrs. ....min.

9. Birthplace: Baltimore City (Town, county, and state)

10. Usual occupation: painter

11. Industry or business: ----

FATHER — 12. Name: Henry Crate

FATHER — 13. Birthplace: Baltimore City

MOTHER — 14. Maiden name: Sophia Stein

MOTHER — 15. Birthplace: Baltimore City

16. Informant: Records of Springfield State Hospital

Address: Sykesville, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov 28, 1948 (month) (day) (year)

Cemetery or crematory:

Location: Baltimore Md.

18. Funeral director: William Cook Inc.

Address: 1217 St Paul St. Balto. Md.

19. Nov 28 1948 (Date rec'd by registrar) C. Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26 1948, at 5.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947, to November 26 1948, and that I last saw him alive on November 26 1948

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	14 yrs
Due to:	
Due to:	
Other conditions: Arthritis	14 yrs
Manic depressive insanity	29 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.: ----

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: ----

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of Injury: ---- Injured at work? ----

23. SIGNATURE: Martin Gross, M.D. Martin Gross, M.D. M. D. or other

Address: Sykesville, Md. Date signed: 11-26-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11287

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Albert Klink Dell

3.(b) Social Security Number: 212-14-7312

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Edna Biggard

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): July 2 1898

8. AGE: Years: 50 Months: 4 Days: 14 If less than one day: hrs. min.

9. Birthplace: md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER — 12. Name: Frank Dell

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Penelope Reese

MOTHER — 15. Birthplace: Md

16. Informant: Mrs Albert K Dell

Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 23/48 (month) (day) (year)

Cemetery or crematory: Wesley

Location: Carroll Co Md

18. Funeral director: Edw Tipton

Address: Hampstead Md

19. Nov. 21 1948 (Date rec'd by registrar) Mrs. M. P. S. Benner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 21 1948 at 6:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Suffocation and burns	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 11-21-48

Where did injury occur? Manchester (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Burned Injured at work? No

23. SIGNATURE: James T. Monod Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed: 11/21/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and complete. Information is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11288

932

Reg. Dist. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor RD 2
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months

Hospital, institution, or street address where death occurred:
New Windsor RD 2

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor RD 2
(If outside city or town limits, write RURAL and give nearest town)

Street No.: New Windsor Rd
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Robert Parker Durham.

3.(b) Social Security Number 216-10-0650

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	W.

6.(b) Name of husband or wife: Annie E Gibson Durham

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 15 1876

8. AGE: Years	Months	Days	If less than one day
71	11	29	..... hrs. ..... min.

9. Birthplace: Wilmington Del
(Town, county, and state)

10. Usual occupation: Plumber

11. Industry or business: -

FATHER
12. Name: James Hooper Durham
13. Birthplace: Hyde Md

MOTHER
14. Maiden name: Mary Kirk
15. Birthplace: Middletown Md

16. Informant: Earl Gibson Durham
Address: Cedarhurst Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-17-48 (month) (day) (year)

Cemetery or crematory: Reisterstown Meth Cemetery

Location: Reisterstown Md

18. Funeral director: Wm Berryman & Sons

Address: Reisterstown MD

19. Nov 15 (Date rec'd by registrar) 194[illegible] Ernest S Bucket Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14 1948, at 3 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1948 to Nov. 14 1948 and that I last saw him alive on Oct 23 1948

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Arteriosclerotic Cardio-Vascular disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Merritt E Robertson M. D. or other

Address: New Windsor, Md. Date signed 11/14/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Months 18 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore 1,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 740 Redwood Street,
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary Dyson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 18, 1916

8. AGE:

Years	Months	Days	If less than one day
32	4	5	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Laundry

11. Industry or business:

FATHER
12. Name: Turner Dyson
13. Birthplace: Marylan

MOTHER
14. Maiden name: Mary Blake
15. Birthplace: Maryland

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 26, 1948 (month) (day) (year)

Cemetery or crematory: Mount Calvary

Location: Brooklyn, Maryland

18. Funeral director: Elroy C. Wilson

Address: 1000 Brantley Ave.

19. November 23, 1948 (Date rec'd by registrar) Albert R. Sandt Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23 1948 at 10:20 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1948, to November 23 1948 and that I last saw h... ER ...alive on November 23, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 11-23-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

11290

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 6-11-47

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? since 6-11-47

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Baltimore County: City

City or town: Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1028 Cathedral Street (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: FICKENSCHER, Charles Conrad

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	wid.

6.(b) Name of husband or wife: Mary Hages, dec.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 5, 1857

8. AGE: Years	Months	Days	If less than one day
91	10	1	..... hrs. ..... min.

9. Birthplace: Baltimore City (Town, county, and state)

10. Usual occupation: Execut. for Union Oil comp.

11. Industry or business

FATHER — 12. Name: Henry Fickenscher

13. Birthplace: Germany

MOTHER — 14. Maiden name: Sophie Neser

15. Birthplace: Germany

16. Informant: Records of Springfield State Hosp. Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/8/48 (month) (day) (year)

Cemetery or crematory: Cathedral Cemetery

Location: Baltimore City, Md.

18. Funeral director: H W Meade & Son

Address: 805 N. Calvert St Balto, Md

19. Nov. 6 1948 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6 1948 at 9.20 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 11 1947 to November 6 1948 and that I last saw him alive on November 6 1948

Immediate cause of death	DURATION
Arteriosclerosis	4 yrs
Due to:	
Due to:	
Other conditions: Senility	11 yrs
Senile psychosis	4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

Martin Gross, M.D.

23. SIGNATURE: Martin Gross, M.D. M. D. or other

Address: Sykesville, Md. Date signed: 11-6-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11291

131a

Reg. Dist. No. 83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural --Woodbine

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo.

Hospital, institution, or street address where death occurred: Hewitt Nursing Home

How long in hospital or institution? 6 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Gaither

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: LAURA J. FOWLER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Vernon Fowler deceased

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb'y 2, 1859

8. AGE: Years	Months	Days	If less than one day
89	9	10	hrs. min.

9. Birthplace: Frederick Co. Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Brice Runkles

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Not Known

MOTHER 15. Birthplace

16. Informant: Mrs. Gertrude Poole

Address: Gaither, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 11-14-48 (month) (day) (year)

Cemetery ~~or crematory~~: New Market

Location: New Market, Frederick Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

18. Nov 14 1948 (Date rec'd by registrar) Edna M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12 1948, at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 1919, to death 1919 and that I last saw h..r alive on November 11 1948

Immediate cause of death	DURATION
(a) Senility -	
Due to (b) Arterio sclerosis hypertensive cardio vascular disease	
Due to (c) Interstitial Nephritis	
Due to (d)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. H. Lawson - M.D. M. D. or other

Address: Westminster Date signed 11/12/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11292

46 P

CERTIFICATE OF DEATH

Reg. Diat. No. 11

1. PLACE OF DEATH:
County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Laura R. Gilds

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: G.F.Sherman ~~Gilds~~ Gilds
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 13,1870

8. AGE: Years	Months	Days	If less than one day
78	5	20	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: House work
11. Industry or business: Own home

FATHER
12. Name: Fred Marquet
13. Birthplace: Germany

MOTHER
14. Maiden name: Christiana Stine
15. Birthplace: Germany

16. Informant: Kenneth R. Gilds
Address: Taneytown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 5, 1948 (month) (day) (year)
Cemetery or crematory: Lutheran Cemetery
Location: Taneytown, Maryland

18. Funeral director: C.O.Fuss & Son
Address: Taneytown, Maryland.

19 Nov 4 19 48 (Date rec'd by registrar)

Mary B. Witt Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 2nd 19 48 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27th 19 48 to November 2nd 19 48 and that I last saw h.e.r. alive on November 2nd 19 48

	DURATION
Immediate cause of death: Carcinoma of Liver	3 years
Due to:	
Due to:	
Other conditions: Gall Stones 3 years.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: B.M.Benner M.D.
M. D. or other
Address: Taneytown, Maryland Date signed Nov. 3, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Check correct page is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11293

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 10 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore 1,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 725 N. Eutaw Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HELEN GREEN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married (Sep.)

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 13, 1915

8. AGE:

Years	Months	Days	If less than one day
33	4	28	hrs. min.

9. Birthplace: Fredrick County, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Deceased

Address:

17. (Burial, cremation, or removal. Which?) Removal Date thereof: Nov 13 48 (month) (day) (year)

Cemetery or crematory: City morgue

Location: Balt. Maryland

18. Funeral director: Mrs Samuel T. Lansky

Address: 574 W. Biddle St.

19. Nov. 10, 1948 (Date rec'd by registrar) Albert R. Swartzbaugh Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10, 1948, at 4:30A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30, 1948, to Nov. 10, 1948 and that I last saw her alive on November 10, 1948

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	June 1947
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Noreen D. Kernan, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 11-10-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use for at age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

11294

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs. 6 mos. 4 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 23 yrs. 6 mo. 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ?
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

Walter Harding

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1869

8. AGE: Years	Months	Days	If less than one day
79			hrs. min.

9. Birthplace: Washington D. C.
(Town, county, and state)

10. Usual occupation: Stone paver

11. Industry or business:

FATHER
12. Name: George Harding
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary C. Hopper
15. Birthplace: Maryland

16. Informant: Hospital records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-28-48 (month) (day) (year)

Cemetery or ~~crematory~~: Springfield

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Nov 27 1948 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 25 1948, at 6:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1946, to Nov. 25 1948 and that I last saw him alive on Nov. 25 1948

Immediate cause of death	DURATION
Myocardial failure due to	23 days
mitral and aortic stenosis	?
XXX Due to: Nephrosclerosis	?
XXX Due to: Pulmonary tuberculosis	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed 11/27/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13-b

11295

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural — Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 8 mos., 5 days

Hospital, institution, or street address (where death occurred): Springfield State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 116½ W. Third St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Nyanza Belle Harper

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Boyd Harper

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 12, 1898

8. AGE: Years	Months	Days	If less than one day
50	7	16	..... hrs. ..... min.

9. Birthplace: Near, Keyser, W. Va.

(Town, county, and state)

10. Usual occupation: Housework & bookkeeping

11. Industry or business:

FATHER

12. Name: Robert Bible

13. Birthplace: W. Va.

MOTHER

14. Maiden name: ?

15. Birthplace: ?

16. Informant: Hospital records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 31 1948 (month) (day) (year)

Cemetery or crematory:

Location: Cumberland Md.

18. Funeral director: A Harry Keen

Address: Sykesville Md.

19. Nov 28 1948 (Date rec'd by registrar) A Harry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 28, 1948 at 5-30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 23, 1948 to Nov. 28, 1948 and that I last saw h[illegible] alive on Nov. 27, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr.
Due to	
Due to	
Other conditions: S. Schizophrenia, paranoid	4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 11/28/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11296

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 6/28/46

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? since 6/28/46

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3120 Cliftmont Avenue, Balto. 13
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: HARTUNG, Albert Theodore

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Maida Bowman

6.(c) If alive, give age: ~~47~~ years

7. Birth date of deceased (mo., day, yr.): September 20, 1895

8. AGE: Years	Months	Days	If less than one day
53	1	23	... hrs. ... min.

9. Birthplace: Baltimore City
(Town, county, and state)

10. Usual occupation: Salesman (advertising business)

11. Industry or business: ---

FATHER
12. Name: John Charles Hartung
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth ?
15. Birthplace: Baltimore, Maryland

16. Informant: Records of Springfield St. Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov-16-48 (month) (day) (year)

Cemetery or crematory: Westview Cemetery

Location: Edmondson Ave

18. Funeral director: Krause Funeral Home

Address: 1216 D. Charles St

19. 11/16 1948 A. W. Fedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13 1948 at 11.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947 to November 13 1948 and that I last saw him alive on November 13 1948

	DURATION
Immediate cause of death: Bronchopneumonia	3 days
Due to:	
Due to:	
Other conditions: Posttraumatic psychosis	2 yrs
Schizophrenia(?)	13 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ---- Date of op. ----

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of ----

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury ---- Injured at work? ----

23. SIGNATURE: Martin Gross, M.D.
Martin Gross, M. D. M. D. or other

Address: Sykesville, Maryland Date signed: 11-13-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly!

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 11297 83

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 mos

Hospital, institution, or street address where death occurred: Road Hills

How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Rural Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Road Hills

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ALONZO ALBERT HELTON

3.(b) Social Security Number: 220-10-5771

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of ~~husband or~~ wife: Minnie A. Helton

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE:

Years	Months	Days	If less than one day
57			hrs. min.

9. Birthplace: Cedar Bluff, Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Not Known

13. Birthplace

MOTHER — 14. Maiden name: Not Known

15. Birthplace

16. Informant: Mrs. Minnie A. Helton

Address: Sykesville, Md.

17. Burial (Burial, ~~cremation, or removal~~ Which?) Date thereof 11-26-48 (month) (day) (year)

Cemetery ~~or crematory~~: Freedom

Location: Freedom, Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. Nov 26 19 48 (Date rec'd by registrar) Edna M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 24 19 48 at 12 30 ~~A~~ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19—— to ——— 19——

and that I last saw h—— alive on ——— 19——

Immediate cause of death	DURATION
(a) Uremia Hypocordial Insufficiency	1/2 hr
Due to: (b) Chronic Nephrosclerosis	1 yr
Due to: (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James T. Marsh Deputy Medical Examiner M. D. or other

Address: Westminster Md. Date signed 11-24-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 11298 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 years, 1 month, 24 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 46 years, 1 month, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Eliza HINKLE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): (unknown) Abt. 1857

8. AGE: Years: 91 | Months: unknown | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: nurse

11. Industry or business:

FATHER
12. Name: Jacob Hinkle
13. Birthplace: Maryland

MOTHER
14. Maiden name: unknown
15. Birthplace: Germany

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-30-48 (month) (day) (year)
Cemetery or crematory: Springfield
Location: Sykesville, Md.

18. Funeral director: C. Harry Weer
Address: Sykesville, Md.

19. Nov. 30 1948 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28, 1948 at 10.15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1942 to November 28, 1948 and that I last saw her alive on November 28, 1948

	DURATION
Immediate cause of death: Coronary occlusion	3 minutes
Due to: arteriosclerosis	about 6 years
Due to:	
Other conditions: Paranoid condition	about 48 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene L. Holsmen M.D.
M. D. or other
Address: Springfield State Hospital Date signed: 11-28-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

11299

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or Institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore 1,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 511 W. Biddle Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: DANIEL BAILEY HOLMES

3.(b) Social Security Number: 211-09-1359

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married (Sep.)

6.(b) Name of husband or wife: Viola Holmes
8.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): June 12, 1904

8. AGE:

Years	Months	Days	If less than one day
44	4	29	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Seaman

11. Industry or business

FATHER
12. Name: Robert Holmes
13. Birthplace: Virginia

MOTHER
14. Maiden name: Alice Watkins
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Nov 15 48
(month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Westport

18. Funeral director: Wm Samuel F. Hemsley
Address: 578 W Biddle St.

19. Nov. 10, 1948
(Date rec'd by registrar)
Albert R. Lowman
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10, 1948 at 6:A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 4, 1948 to Nov. 10, 1948 and that I last saw him alive on November 10, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben H. Lowman, M.D.
M. D. or other
Address: Henryton, Maryland
Date signed: 11-10-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

48 b

11300

Reg. Diat. No. 83

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Woodbine

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Woodbine

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Grace Eleanor Dorsey House

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Separated

6.(b) Name of husband or wife Wade House

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1887

8. AGE: Years	Months	Days	If less than one day
61	2	14	hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Frank W. Dorsey

13. Birthplace Md.

MOTHER 14. Maiden name Annie L. Ritter

15. Birthplace Md.

16. Informant Mrs. B. Frank Dorsey

Address Woodbine, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-3-48 (month) (day) (year)

Cemetery or crematory St. Joseph's

Location Sykesville, Md.

18. Funeral director C. Harry Weer

Address Sykesville, Md.

19. Dec. 2 1948 (Date rec'd by registrar) Edna M. Hewlett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1948, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1948 19..., to Nov. 30, 1948 19...

and that I last saw her alive on Nov. 30, 1948 19...

	DURATION
Immediate cause of death: Profound secondary anemia	2 mo
Due to: Carcenoma of uterus	2 yrs
Due to:	
Other conditions: General Carcenomatosis	6 mo

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Stanley Grabill M. D. or other

Address Mt. Airy, Md. Date signed 12/1/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

11301

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 18 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 year, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ~~Maryland~~ Maryland County Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 534 Columbia Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Viola Marie Humbertson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Russell Humbertson
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 31, 1892

8. AGE: Years	Months	Days	If less than one day
56	8	2	____ hrs. ____ min.

9. Birthplace: Eckhart Mines, Maryland
(Town, county, and state)
10. Usual occupation: Maid work
11. Industry or business:

FATHER
12. Name: Isaac Porter
13. Birthplace: Eckhart Mines, Maryland

MOTHER
14. Maiden name: Ella Nelson
15. Birthplace: Eckhart Mines, Maryland

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 6-48 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetary
Location: Cumberland Md.
18. Funeral director: John J. Hafer
Address: 230 Balto ave Cumberland

19. Nov. 4 1948 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 2, 1948 at 10.05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28, 1948, to November 2, 1948 and that I last saw her alive on November 2, 1948

Immediate cause of death	DURATION
Cerebral hemorrhage	4 days
Due to: xxx Broncho-pneumonia	3 days
Due to:	
Other conditions: Involutional psychosis, agitated, depressed type	about 2 years

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Irene Hebeman M.D (M. D. or other)
Address: Springfield State Hospital Date signed: 11-3-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11302

Reg. Dist. No. 24

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 1 month, 20 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore 23,
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 9 N. Schroeder Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Estella Lee Johnson

3. (b) Social Security Number: 245-01-5827

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
feamle	Col.,	Married

6.(b) Name of husband or wife: Ernest Johnson

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): August 15, 1922

8. AGE: Years	Months	Days	If less than one day
26	3	5	...hrs. ...min.

9. Birthplace: Bethel, N. Carolina
(Town, county, and state)

10. Usual occupation: Clothes Company

11. Industry or business:

FATHER
12. Name: Robert Lee
13. Birthplace: N. Carolina

MOTHER
14. Maiden name: Martha Williams
15. Birthplace: N. Carolina

16. Informant: Deceased
Address:

Burial, cremation, or removal. Which?: Burial Date thereof: Nov 23 1948 (month) (day) (year)

Cemetary or crematory: Mt. Carmel

Location:

18. Funeral director: Adolphus Hartland

Address: 918 Druid Hill Ave

19. November 20, 1948 (Date rec'd by registrar) Albert R. Sonnheim Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20, 1948, at 4:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 30, 1947 to November 20, 1948 and that I last saw her alive on November 20, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ...Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 11-20-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11303

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos., 14 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 4 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore 20
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 15, Box 285
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME John Kaufman

3.(b) Social Security Number 217-22-8209

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Anna Elsa Kaufman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 9, 1882

8. AGE:

Years	Months	Days	If less than one day
66	7	21	..... hrs. ..... min.

9. Birthplace: Kansas
(Town, county, and state)

10. Usual occupation: Policeman, SGT.

11. Industry or business: Retired - BALTO. Police Dept

FATHER
12. Name: William Kaufman
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Frances Beggs
15. Birthplace: Iowa

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 - 4 - 48 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Baltimore, Md.

18. Funeral director: HENRY SANDER & SONS, INC.
Address: NORTH AVE. & BROADWAY

19. Dec 2 1948 (Date rec'd by registrar) a.w. Holmes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 30, 1948 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16, 1948, to Nov. 30, 1948 and that I last saw him alive on Nov. 30, 1948

	DURATION
Immediate cause of death: Hypertensive cardiovascular disease	?
Due to: Generalized arteriosclerosis	?
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	11 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other

Address: Springfield State Hospital Date signed 11/30/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 13b 11304

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 11 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore 30,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1421 Ward Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Catherine Rebecca Kiah

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col.	Separated

6.(b) Name of husband or wife: Aurthur Kiah

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): December 19, 1929

8. AGE: Years	Months	Days	If less than one day
18	10	26	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Ernest Gales
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha Houston
15. Birthplace: Maryland

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 20. 1948 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemetery
Location: Balto Md

18. Funeral director: Mrs Katie R. Williams
Address: 325 N. Schroeder St

19. November 15, 1948 (Date rec'd by registrar) Albert R. Sewell Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15, 1948 at 11:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4, 1948 to November 15, 1948 and that I last saw her alive on November 15, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	January 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Roman M.D.
M. D. or other

Address: Henryton, Maryland Date signed 11-15-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Bc 462 ✓ 11305

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since March 6, 1948

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? since March 6, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2114 Eastern Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: KOZAK, Joseph

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary Kozak

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ?1887?

8. AGE: Years	Months	Days	If less than one day
61?	?	?	hrs. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual occupation: Shoemaker

11. Industry or business:

FATHER — 12. Name: Simon Kozak

13. Birthplace: Poland

MOTHER — 14. Maiden name: Catherine (?)

15. Birthplace: Poland

16. Informant: Records of Springfield State Hosp.

Address: Sykesville, Md. 11-10-48

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery: ST. STANISLAUS

Location: BALTIMORE, Md.

18. Funeral director: George R Weber

Address: 705 South Arnold St

19. Nov 8 19 48 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6 1948, at 12.15P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 4 1948, to November 6 1948

and that I last saw him alive on November 6 1948

Immediate cause of death	DURATION
Carcinoma metastases of lungs	6 mo ?
Due to: Adenocarcinoma of rectum more	than 1 yr
Due to:	
Other conditions: Schizophrenia	30 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. ---

Autopsy results: metastatic Carcinoma of lungs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of ---

Where did injury occur? --- (City or town) --- (County) --- (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE: Martin Gross, M.D.
Martin Gross, M.D.
M. D. or other

Address: Sykesville, Md. Date signed 11-6-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46 b

11306

CERTIFICATE OF DEATH

Reg. Dist. No. 81

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alice Adele La Forge

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Guy S La Forge

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 23 - 1881

8. AGE:

Years	Months	Days	If less than one day
67	5	30	..... hrs. ..... min.

9. Birthplace Belleville, Ill.

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER

12. Name F W Bechtold

13. Birthplace Illinois

MOTHER

14. Maiden name Maximillina Kistler

15. Birthplace Illinois

16. Informant Guy S La Forge

Address Union Bridge, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 26-1948 (month) (day) (year)

Cemetery or crematory Pipe Creek Cemetery

Location Uniontown Road

18. Funeral director D D Hartzler & Sons

Address Union Bridge & New Windsor, Md

19. Nov. 23 1948 (Date rec'd by registrar) R Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1948 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 19 48 to Nov 22 1948

and that I last saw her alive on Nov 22 1948

Immediate cause of death Carcinoma Stomach

Carcinoma Transverse Colon

DURATION 6 months

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE James T Marsh MD M. D. or other

Address Westminster Md Date signed 11/23/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

11307

CERTIFICATE OF DEATH

Reg. Dist. No. 75

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos.

Hospital, Institution, or street address where death occurred: Long View Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Mary E Lauer.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Levi Lauer

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Sept 12 - 1875

8. AGE:

Years	Months	Days	If less than one day
73	2	9	...hrs. ...min.

9. Birthplace: md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Jacob Frederick

13. Birthplace: Md

MOTHER — 14. Maiden name: Elizabeth Stine

15. Birthplace: Md

16. Informant: Levi Lauer

Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 24/48 (month) (day) (year)

Cemetery or crematory: Shemans

Location: York Co Penna

18. Funeral director: Edw C Fulton

Address: Hampstead Md

19. Nov. 21st 1948 (Date rec'd by registrar) Mrs. W. P. S. Benner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21 1948, at 3P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1948, to Nov 21 1948 and that I last saw h[illegible] alive on November 20 1948

	DURATION
Immediate cause of death: Chronic Myocarditis.	7
Due to: Hypertensive Cardio-Vascular Disease	
Due to:	
Other conditions: Cerebral Hemorrhage.	3 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State) —

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Joseph E. Buck M.D. M. D. or other

Address: Hampstead Md Date signed 11-21-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

11308

CERTIFICATE OF DEATH

Reg. Diat. No. 72

1. PLACE OF DEATH:

County: Carroll

City or town: Near Silver Run
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
Westminster, R. D. 1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Near Silver Run
(If outside city or town limits, write RURAL and give nearest town)

Street No. Westminster, R. D. 1
(If rural, give LOCATION)

2.(a) If veleran, name war

3.(a) FULL NAME George W. C. Leppo (George Wellington Cleason Leppo)

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie K. (Bowman) Leppo

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): February 25 1869

8. AGE: Years	Months	Days	If less than one day
79	8	16	hrs. min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business: Farm

FATHER
12. Name: William A. Leppo
13. Birthplace: Carroll County, Md.

MOTHER
14. Maiden name: Sarah J. Koontz
15. Birthplace: Carroll County, Md.

16. Informant: Mrs Annie Leppo
Address: Westminster, Md. R. D. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/14/48 (month) (day) (year)

Cemetery or crematory: St. Marys Union Cemetery

Location: Silver Run, Md.

18. Funeral director: J. M. Little & Son

Address: Littlestown, Pa. Per - R. A. Little

19. Nov. 12 - 1948 (Date rec'd by registrar) Calvin E. Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 11 1948 at 11 30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Cerebral Hemorrhage — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE James T. Marsh Deputy Medical Examiner
M. D. or other

Address: Date signed 11/11/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name if is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11309

Reg. Diat. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Rural-- Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: BALTIMORE
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 105 Old Court Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ADDIE B. LINDSAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Jesse L. Lindsay deceased
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 23, 1880

8. AGE: Years	Months	Days	If less than one day
68	8	7	hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: Charles W. Franklin
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie A. Barnes
15. Birthplace: Maryland

16. Informant: Mrs. Carvel Horton
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-4-48 (month) (day) (year)
Cemetery or crematory: St. James
Location: Dennings, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. 12/2 19 40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 30, 19 48 at 10;55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute decompensation	
Due to: Hypertensive C-V disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Monroe Deputy Medical Examiner
M. D. or other
Address: Westminster Md. Date signed: Dec 2-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

11310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos., 3 days

Hospital, institution, or street address (where death occurred): Springfield State Hospital

How long in hospital or institution? 3 mos., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1921 E. Fairmount Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Lena Lopez

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 24, 1924

8. AGE: Years	Months	Days	If less than one day
24	8	20	..... hrs. ..... min.

9. Birthplace: Puerto Rico (Town, county, and state)

10. Usual occupation: Typist

11. Industry or business:

FATHER — 12. Name: John Lopez

13. Birthplace: Puerto Rico

MOTHER — 14. Maiden name: Isabel Beres

15. Birthplace: Puerto Rico

16. Informant: Hospital records

Address:

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Nov. 16, 1948 (month) (day) (year)

Cemetery or crematory:

Location: Puerto Rico

18. Funeral director: Williams Rock, Inc.

Address: 1217 E. Pauls St. Balto. Md.

19. Nov. 15 1948 (Date rec'd by registrar) C. Henry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14, 1948 at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 11, 1948, to Nov. 14, 1948

aed that I last saw h[illegible] alive on Nov. 13, 1948

	DURATION
Immediate cause of death: Pulmonary tuberculosis	4 mos. (known)
Due to:	
Due to:	
Other conditions: Schizophrenia, paranoid type	6 mos.

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M.D. or other

Address: Springfield State Hospital Date signed: 11/14/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11311

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 26 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore County

City or town: Cockeysville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Reason Thomas Lynch

3. (b) Social Security Number: 578-22-9036

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary Lynch

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): February 28, 1889

8. AGE: Years	Months	Days	If less than one day
59	9	2	...hrs. ...min.

9. Birthplace: Montgomery, County, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Robert Lynch

13. Birthplace: Montgomery, County Maryland

MOTHER — 14. Maiden name: Mary Norman

15. Birthplace: Montgomery County Maryland

16. Informant: Patient

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 4 - 48 (month) (day) (year)

Cemetery or crematory: Sugarland

Location: Sugarland Md.

18. Funeral director: Joseph Janifer

Address: 1141 22 St. N.W. Washington D.C.

19. November 30 19 48 (Date rec'd by registrar) Albert R. Stansbury Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 19 48 at 4:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4 19 48 to November 30 19 48 and that I last saw him alive on November 30 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Maryland Date signed: Nov. 30, 1948

Evidence for change of birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11312

HLM No. G 118 NOV 23 1948 **CERTIFICATE OF DEATH**

Reg. Dist. No. 81

1. PLACE OF DEATH:
County: Carroll Co
City or town: Union Bridge Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For children infants give residence of mother)
State: Md County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Samuel Josiah MacKley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 4 - 1864 1862

8. AGE: Years	Months	Days	If less than one day
86	8	11	hrs. min.

9. Birthplace: Penn (Town, county, and state)
10. Usual occupation: Junk Dealer
11. Industry or business:
FATHER 12. Name: Jacob L. MacKley
13. Birthplace: Adams Co Pa
MOTHER 14. Maiden name: Lucinda Harbaugh
15. Birthplace: Frederick Co Md
16. Informant: Mrs Grace Eckenrode
Address: Union Bridge Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-18-48 (month) (day) (year)
Cemetery or crematory: Beaver Dam
Location: Near Union Bridge Md
18. Funeral director: Raymond K. Wright
Address: Union Bridge Md
19. Nov 17 1948 Julia L. Repp
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 16 1948 at 6 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 14 1948 to Nov 16 1948 and that I last saw h. alive on Nov 15 1948

Immediate cause of death	OURATION
Intestinal Flu	
Due to: Cerebral arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. A. Legg M. D. or other
Address: Union Bridge Date signed 11-16-48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11313

92d

CERTIFICATE OF DEATH

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll Co.

City or town Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All his life

Hospital, Institution, or street address where death occurred: Carrollton

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural, near Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. Carrollton station
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Carroll C. Magee

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 10, 1867

8. AGE: Years 81 | Months 5 | Days 10 | If less than one day ... hrs. ... min.

9. Birthplace Carrollton, Carroll Co. Md.
(Town, county, and state)

10. Usual occupation poultry raiser

11. Industry or business

FATHER
12. Name Hose Magee
13. Birthplace Maryland

MOTHER
14. Maiden name Elinor Cole
15. Birthplace Md. Carroll Co.

16. Informant Lionel Lockard
Address Westminster, Md. Balto. Blvd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 1. 48 (month) (day) (year)
Cemetery or crematory Carrollton Church of God Cemetery
Location Rural, near Westminster

18. Funeral director J. E. Powers
Address Westminster. Md.

19. 11 30 19 48 L C Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1948 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1948, to November 28 1948
and that I last saw him alive on November 29 1948

	DURATION
Immediate cause of death Coronary occlusion	Few hours
Due to Arteriosclerosis generalized	Several years
Due to Myocardial degeneration	Yrs
Due to Coronary thrombosis & Valvular insufficiency	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other

Address Westminster Md. Date signed 11/30/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a Ca 11314

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years, 3 months, 24 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 28 years, 3 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2805 Alameda Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Menkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: William Menkins

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 27, 1887

8. AGE: Years	Months	Days	If less than one day
61	4	17	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: House work

11. Industry or business:

FATHER — 12. Name: Edward Kriegbaum; 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Anna Hessenauer; 15. Birthplace: Maryland

16. Informant: Hospital records

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-17-48 (month) (day) (year)

Cemetery or crematory: Glen Haven Cem.

Location: Glen Burnie, Md.

18. Funeral director: Williams Cook, Inc.

Address: 1217 St Paul St.

19. Nov. 15 1948 C. Harry Weer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14, 1948, at 11.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1942 to November 14, 1948 and that I last saw her alive on November 14, 1948

Immediate cause of death	DURATION
Diabetic coma	1 day
Diabetes mellitus	unknown
Due to: Accidental fracture of femur	4 days
Due to:	
Other conditions: Schizophrenia, paranoid type	30 years

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Nov. 1948

Where did injury occur? Springfield S. Hosp. (City or town) Carroll Co. Md. (County) (State)

Injured at home, farm, industry, public place (where?): Hosp.

Means of injury: Fall Injured at work? —

23. SIGNATURE: Irene Hickmott, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 11-14-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

B37a

11315

CERTIFICATE OF DEATH

Reg. Dist. No. 72

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Myers District
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
Littlestown, Pa. R.D.1 (Mailing Address)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. D. 7
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jacob Henry Myers

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Virginia (Eckard) Myers
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Sept. 19, 1862

8. AGE: Years	Months	Days	If less than one day
86	2	7	...hrs. ...min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business: Farming (Retired)

FATHER
12. Name: Samuel Myers
13. Birthplace: Carroll County, Md.

MOTHER
14. Maiden name: Harriet Dutterer
15. Birthplace: Carroll County, Md.

16. Informant: Mrs Laurence Haines
Address: Littlestown, Pa. R.D.1, Carroll Co.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/29/48 (month) (day) (year)
Cemetery or crematory: St. Marys Union Cemetery
Location: Silver Run, Md.

18. Funeral director: A. W. Tuttle & Son
Address: Littlestown, Pa. Per R. A Tuttle

19. Nov. 29th, 1948 (Date rec'd by registrar) Calvin T. Bankert, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26 1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1948 to Nov. 26 1948 and that I last saw him alive on Nov. 26 1948

Immediate cause of death	DURATION
Hypertrophy of Prostate gland	10 yrs
Due to	
Due to	
Other conditions Chronic cardio Vascular disease	15 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Hypertrophy of prostate gland
Date of op. April 5, 1948
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: David B Cover, M.D.
M. D. or other
Address: Littlestown Pa Date signed 11-26-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11316

93d

Reg. Diat. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rurel, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William A.Myers

3.(b) Social Security Number: 218-10-9540

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Mary McKinney Myers
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec.14,1881

8. AGE: Years	Months	Days	If less than one day
66	10	22	..... hrs. ..... min.

9. Birthplace: Md
(Town, county, and state)
10. Usual occupation: Retired Bus Driver
11. Industry or business
FATHER 12. Name: Frederick H.Myers
13. Birthplace: Md
MOTHER 14. Maiden name: Elenora Geiman
15. Birthplace: Md
16. Informant: Mrs.Mary McKinney Myers
Address: Westminster,Md. R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov.8,1948 (month) (day) (year)
Cemetery or crematory: St.Matthews
Location: Pleasant Valley,Md.
18. Funeral director: C.O.FUSS & SON
Address: Taneytown,Md.
19. NOV 8 '48 19 ..... (Date rec'd by registrar) Clay Fogle Dep Lar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 5 - 1948 at 2:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to Nov. 5 - 1948
and that I last saw h...i.M. alive on Nov. 4 - 48 1948

Immediate cause of death	DURATION
Myocarditis (chr)	
Nephritis (Chr)	
Due to	
Due to	
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE: W. C. Jennette M.D. M. D. or other
Address: Westminster Md. Date signed 11-6-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

#33

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11317

107

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since January 28, 1947

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? since January 28, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Williamsport

(If outside city or town limits, write RURAL and give nearest town)

~~Street No.~~ Route #2

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: NEWCOMER, Lewis Stanop

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife: Maude Tice, deceased

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): August 19, 1878

8. AGE:

Years	Months	Days	If less than one day
70	2	16	... hrs. ... min.

9. Birthplace: Washington County, Maryland (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: ---

FATHER

12. Name: John Robert Newcomer

13. Birthplace: Washington County, Maryland

MOTHER

14. Maiden name: Josephine Heffner

15. Birthplace: Washington County

16. Informant: Records of Springfield St. Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 7 48 (month) (day) (year)

Cemetery or crematory: Riverview

Location: Williamsport md

18. Funeral director: Leaf Funeral Home per Howard J. Hoke

Address: Williamsport md

19. Nov 4 1948 (Date rec'd by registrar) C. Harry Zile Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4 1948 at 12:25 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1947 to XI-3 1948 and that I last saw him alive on November 3 1948

	DURATION
Immediate cause of death: Bronchopneumonia	2 days
Due to: Renal and cerebral arteriosclerosis	about 2 yrs
Due to:	
Other conditions: Hematuria	1 day

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.: ---

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Martin Gross, M. D. M. D. or other

Martin Gross, M.D.

Address: Sykesville, Maryland Date signed: 11-4-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

11318

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 1 day
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore 2,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 700 Sterling Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Herbert Lee Northington

3.(b) Social Security Number: 218-03-1201

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Separated

6.(b) Name of husband or wife: Mary Northington
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): October 10, 1907

8. AGE: Years	Months	Days	If less than one day
41	1	5	hrs. min.

9. Birthplace: Buchanan, Virginia
(Town, county, and state)
10. Usual occupation: Metal Cleaner
11. Industry or business

FATHER
12. Name: Richard Northington
13. Birthplace: Virginia

MOTHER
14. Maiden name: Emma Harris
15. Birthplace: Virginia

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 18-48 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cem.
Location: Broadneck, Md
18. Funeral director: Elroy O. Wilson
Address: 1000 Brantley, ave

19. November 15, 1948 (Date rec'd by registrar) Allen R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15, 1948 at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 14, 1948 to November 15, 1948 and that I last saw him alive on November 15, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1948
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Fuman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 11-15-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

11319

Reg. Dist. No. 74

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Sept. 25, 1940

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? since Sept. 25, 1940

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: ?

City or town: ? (If outside city or town limits, write RURAL and give nearest town)

Street No. ? (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Henry Schroeder

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife: /

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 1881

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
67	/	/		

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: laundry worker

11. Industry or business:

FATHER — 12. Name: Christian Schroeder

13. Birthplace: Germany

MOTHER — 14. Maiden name: Mary Smetzer

15. Birthplace: Germany

18. Informant: Springfield State Hospital, Sykesville, Maryland

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 11-20-48 (month) (day) (year)

Cemetery or crematory:

Location: 1217 St. Paul St. Balto. Md.

18. Funeral director: Williams Cook Inc.

Address: 1217 St. Paul St. Balto. Md.

19. Nov 20 1948 (Date rec'd by registrar) C. Henry Wood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18, 1948, at 11:31 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1, 1947, to Nov. 18, 1948, and that I last saw him alive on Nov. 18, 1948

Immediate cause of death	DURATION
cerebral hemorrhage	a few hours
Due to	
Due to cerebral arteriosclerosis, chronic alcoholism, bronch. asthma	for more than 8 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Martin Gross, M. D. (M. D. or other)

Address: Sykesville Md. Date signed: 11-19-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

11320

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 Hours

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore 1,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 600 W. Mulberry Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Naomi Estelle Simms

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col.	Separated

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 19, 1914

8. AGE:

Years	Months	Days	If less than one day
34	9	16	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Clifton Mulberry
13. Birthplace: (unknown)

MOTHER
14. Maiden name: (unknown)
15. Birthplace: (unknown)

16. Informant: Mrs. Delores Brown
Address: 822 Druid Hill Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 9 1948 (month) (day) (year)

Cemetery or crematory: Mt Auburn.

Location: Baltimore Maryland

19. Funeral director: J. Halstead

Address: 918 Druid Hill Ave.

19. November 5, 1948 (Date rec'd by registrar) Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5, 1948 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 4, 1948 to November 5, 1948 and that I last saw her alive on November 5, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben A. Forman, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 11-5-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11321

61

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll, Uniontown District
City or town: Westminster RD #7
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, Institution, or street address where death occurred: RD #7
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #7
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alice Alp Sipe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: William Sipe
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 28 1875

8. AGE: Years 73 | Months 8 | Days 25 | If less than one day: hrs. min.

9. Birthplace: York Co Pa (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business:

FATHER
12. Name: William F. Alp
13. Birthplace: York Co Pa

MOTHER
14. Maiden name: Lora Harner
15. Birthplace: York Co Pa

16. Informant: Ethel G. Sipe
Address: NW. Lansdale N. J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 26 1948 (month) (day) (year)
Cemetery or crematory: Shrewsbury Cemetery
Location: Shrewsbury Pa

18. Funeral director: H. C. Fraser
Address: Hanover Pa.

19. 11/24 19 48 L. Lawrence Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 23 19 48 at 9:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 47, to Nov 23 19 48 and that I last saw h[illegible] alive on Nov 22 19 48

Immediate cause of death: acute cardiac decompensation — DURATION 12 hrs
Due to: chronic myocarditis — 1 yr
Due to: arteriosclerosis — 1 yrs
Due to: diabetes mellitus — 5 yrs
Due to:
Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas R Fouts MD
M. D. or other
Address: Westminster Md Date signed 11-24-48

M

(I)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11322

74a

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Hampstead

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Hampstead

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Howard Samuel Snyder

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Minnie Shaeck

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) July 17-1873

8. AGE: Years 76 | Months 4 | Days 1 | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER — 12. Name Wm H Snyder

13. Birthplace Md

MOTHER — 14. Maiden name Eva R Garrett

15. Birthplace Md

16. Informant Mrs Minnie Snyder

Address Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 21/48 (month) (day) (year)

Cemetery or crematory Snydersburg

Location Carroll Co Md

18. Funeral director Edw C Tipton

Address Hampstead Md

19. Nov. 20 1948 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1948 at 10:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions Leukemia	3 yrs +

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel T Shaw Deputy Medical Examiner M. D. or other

Address Westminster Md Date signed 11-18-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11323

30g

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since October 17, 1938

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or Institution? since October 17, 1938

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ?

City or town: ?

(If outside city or town limits, write RURAL and give nearest town)

Street No.: ?

(If rural, give LOCATION)

2.(a) If veteran, name war: ----

3. (a) FULL NAME: SPRINGER, Albert

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: ?

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Febr. 10, 1874

8. AGE: Years	Months	Days	If less than one day
74	9	11	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Bartender

11. Industry or business

FATHER — 12. Name: Max Springer

13. Birthplace: Bavaria

MOTHER — 14. Maiden name: Martha Benjamin

15. Birthplace: Maryland

16. Informant: Records of Springfield State Hospital

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-22-48 (month) (day) (year)

Cemetery or crematory: Baltimore Hebrew

Location: Balto. Md.

18. Funeral director: David Sandhaus

Address: 1902 Eutaw Place

19. Nov. 24 1948 (Date rec'd by registrar) C. Harry Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21 1948 at 10,05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8 1947, to November 21 1948

and that I last saw him alive on November 21 1948

	DURATION
Immediate cause of death: Chronic myocarditis and myocardial degeneration plus pyelonephritis	unknown
Due to:	
Due to:	
Other conditions: Psychosis with pulmonary tuberculosis, systemic syphilis (Include pregnancy within 3 months of death)	more than 10 yrs

Major findings of operation: ----

Autopsy results: brain atrophy, arteriosclerosis, chron. myocarditis, pyelonephritis

Date of op. ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of ----

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) ----

Means of injury ---- Injured at work? ----

23. SIGNATURE: Martin Gross, M.D. M. D. or other

Address: Sykesville, Md. Date signed 11-21-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11324

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name if possible. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Caroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8-19-47

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 8-19-47

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1426 N. Decker Street (If rural, give LOCATION)

2.(a) If veteran, name war: /

3.(a) FULL NAME Lewis Stamboni

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Singie, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife: /

7. Birth date of deceased (mo., day, yr.): 4-20-76 6.(c) If alive, give age: years

8. AGE: Years	Months	Days	If less than one day
72	7	5	hrs. min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: /

FATHER 12. Name: Joseph Stamboni

FATHER 13. Birthplace: Italy

MOTHER 14. Maiden name: ?

MOTHER 15. Birthplace: Italy

16. Informant: Springfield State Hospital Address: Syksville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 29. 1948. (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Belair Road.

18. Funeral director: Wendell Hyser

Address: 312.5. Edmondson Ave

19. Nov. 25 1948 (Date rec'd by registrar) C. Harry Kerr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25, 1948, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1948, to November 25 1948 and that I last saw him alive on November 25, 1948

Immediate cause of death	DURATION
bronchopneumonia	
chronic myocarditis and myocardial degeneration	3 days
Due to	
Due to cerebral arteriosclerosis	6 years
Other conditions psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations: / Date of op.

Autopsy results: /

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: / Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): /

Means of injury: / Injured at work?

23. SIGNATURE: Elizabeth A. Wimiarz M.D. M. D. or other

Address: Springfield State Hospital Date signed: Nov. 25. 48

11325

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

Reg. Diat. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Rural Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles F. Steger

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Mary E. Steger (deceased)
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 18 1874
8. AGE: Years: 74 Months: 5 Days: 8 If less than one day: ..... hrs. ..... min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Carl E. Steger
13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
15. Birthplace: Germany
16. Informant: Walter Steger
Address: Manchester Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-28-48 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md
18. Funeral director: Hart Wenk's Sons
Address: Manchester. Md.
19. Nov. 27th 1948 Mrs. W. P. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26 1948 7:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 23, 1948, to Nov. 26 1948
and that I last saw him alive on Nov. 25 1948

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 da.
Due to: Hypertensive Cardio-Renal Vascular Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jas. E. Bush M. D. or other
Address: Hampstead Md. Date signed 11/27/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 11326

Reg. Dist. No. 75

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred:
Longview Nursing Home

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Upperco, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. ____
(If rural, give LOCATION)

2.(a) If veteran, name war ____

3.(a) FULL NAME: Margaret F. Stocksdale

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow -

6.(b) Name of husband or wife: William Stocksdale

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): August 15, 1863

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
85	2.	17.		

9. Birthplace: Fredrick County Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: ____

FATHER
12. Name: George Metzing
13. Birthplace: Germany.

MOTHER
14. Maiden name: Wilhelmenia Ribear
15. Birthplace: Germany.

16. Informant: Mrs M. May Wunderdmark

Address: Upperco, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 3/48 (month) (day) (year)

Cemetery or crematory: St Paul's

Location: Balto Co Md

18. Funeral director: Edward Gupton

Address: Hampstead Md

19. Nov 2 1948 (Date rec'd by registrar) Mrs. R. S. Lennon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1 1948, at 10 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18 1948 to November 1 1948 and that I last saw h[illegible] alive on October 31 1948

	DURATION
Immediate cause of death: Hypostatic Pneumonia	72 hrs
Due to: Chronic Myocarditis	
Due to: Generalized Arterio-sclerosis	
Other conditions: General Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Joseph E. Beard M.D.
M. D. or other

Address: Hampstead Md. Date signed 11-1-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 11327

CERTIFICATE OF DEATH

Reg. Diat. No. 75

1. PLACE OF DEATH:
County Carroll
City or town Manchester, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? - 73 yrs -
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war No.

3.(a) FULL NAME Herman phillip Stoffle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife None
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARch 23 - 1875

8. AGE: Years	Months	Days	If less than one day
73	7	15	hrs. min.

9. Birthplace Manchester, Md.
(Town, county, and state)
10. Usual occupation - Laborer
11. Industry or business

FATHER
12. Name Sebastian Stoffle
13. Birthplace Germany

MOTHER
14. Maiden name - Mary Hersh
15. Birthplace Germany

16. Informant Horatio B. Stoffle
Address Manchester, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-11-48 (month) (day) (year)
Cemetery or crematory Cemetery
Location Manchester Md
18. Funeral director Jacob Winter's Sons
Address Manchester Md.
19. Nov. 10th 1948 Mrs. W. P. S. Benner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1948 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1947 to Nov 8 1948 and that I last saw him alive on Nov 8 1948

Immediate cause of death	DURATION
Arteriosclerotic Heart Disease	About 5 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. H. Froard
M. D. or other
Address Manchester, Md Date Signed Nov 9-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5b 11328

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant give residence of mother)

State Maryland County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edward J. Stuller

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife Ada V. Stuller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 28-1866

8. AGE:

Years	Months	Days	If less than one day
82	8	17	..... hrs. ..... min.

9. Birthplace Carroll County, Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name John Stuller

13. Birthplace Maryland

MOTHER 14. Maiden name Beal Young

15. Birthplace Maryland

16. Informant Mrs. Ada V. Stuller

Address New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 20-'48 (month) (day) (year)

Cemetery or crematory Winters Cemetery

Location Union Bridge Road

18. Funeral director C. O. Fairbrother & Sons

Address Union Bridge & New Windsor, Md.

19. 11/19/48 19..... Margaret P. Englar Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1948 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to Nov. 1948

and that I last saw him alive on Nov. 15 1948

Immediate cause of death	DURATION
Carcinoma, Prostate	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Merritt E. Robertson M. D. or other

Address New Windsor, Md Date signed Nov 18, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Bc 11329

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore 30,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 702 S. Charles Street
(If rural, give LOCATION)

2.(a) If veteran, name war: No ✓

3. (a) FULL NAME: Sam Sumter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 24, 1924

8. AGE: Years	Months	Days	If less than one day
24	7	26	hrs. min.

9. Birthplace: Columbia, S. Carolina
(Town, county, and state)

10. Usual occupation: Fruitman

11. Industry or business:

FATHER — 12. Name: Thomas Sumter

13. Birthplace: S. Carolina

MOTHER — 14. Maiden name: Lottie Benson

15. Birthplace: S. Carolina

16. Informant: Deceased

Address:

17. Burial, cremation, or removal. Which?: Burial Date thereof: 11-24-48 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: a. a. Co. Md

18. Funeral director: James A. Hayes

Address: 142 W. Hill St

19. (Date rec'd by registrar): November 20, 1948 Albert R. Trueblood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20, 1948 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 16, 1948 to November 20, 1948 and that I last saw him alive on November 20, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	unknown
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Lyman M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 11-20-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11330

Reg. Dist. No. 14

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 29 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 921 Linden Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Isaih Henry Wallace

3.(b) Social Security Number: 212-03-8162

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Emma Wallace

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): April 4, 1884

8. AGE: Years	Months	Days	If less than one day
64	7	9	...hrs. ...min.

9. Birthplace: Montgomery County, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Urgah Wallace

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Lucy Wing

15. Birthplace: Maryland

16. Informant: Deceased

Address:

17. Burial, cremation, or removal. Which?: Burial Date thereof: 11/18/48 (month) (day) (year)

Cemetery or crematory: Arbutus Park

Location: Baltimore, Md.

18. Funeral director: Mrs. Emmanuel T. Kennedy

Address: 5-78 W Biddle St.

19. (Date rec'd by registrar) November 13, 19 48 — Albert R. Swandbourg, Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13, 19 48, at 6:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15, 19 48, to November 13, 19 48 and that I last saw him alive on November 13, 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. (M. D. or other)

Address: Henryton, Maryland Date signed: 11-13-48

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11892

Reg. Dist. No. 81

1. PLACE OF DEATH:
County: Carroll
City or town: Uniontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Uniontown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Caleb N. Wolfe

3.(b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed or divorced: married
6.(b) Name of husband or wife: Fannie D. Wolfe
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov. 20 - 1871
8. AGE: Years: 77 Months: 0 Days: 1 If less than one day: hrs. min.
9. Birthplace: Frederick County, Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Daniel Wolfe
13. Birthplace: Maryland
MOTHER 14. Maiden name: Rebecca Gaver
15. Birthplace: Maryland
16. Informant: Charles M. Wolfe
Address: Uniontown, Maryland
17. Burial, cremation, or removal. Which?: Burial Date thereof: Nov. 24-'48 (month) (day) (year)
Cemetery or crematory: Pipe Creek Cemetery
Location: Union Bridge R.D. Md.
18. Funeral director: D. H. Hartley & Sons
Address: Union Bridge & New Windsor Md
19. Nov. 22 1948 (Date rec'd by registrar) J. Eichman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21 1948 at 12 NOON

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 21 1948 to Nov. 21 1948
and that I last saw him alive on Nov. 21 1948

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to:	
Due to: Chronic Myocarditis	
Other conditions: 4329 932	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. A. Marston M.D. M. D. or other
Address: Union Bridge Date signed: Nov 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11331

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 5 mos., 9 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs., 5 mos., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Frederick

City or town: Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 329 N. Bentz St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Ethel Marie Young

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Kenneth W. Young

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 4, 1906

8. AGE:

Years	Months	Days	If less than one day
42	8	24	..... hrs. ..... min.

9. Birthplace: Frederick County, Md.

(Town, County, and state)

10. Usual occupation: Waitress

11. Industry or business

FATHER

12. Name: William H. Traylugh

13. Birthplace: Hancock, Md.

MOTHER

14. Maiden name: Claudia H. Ponton

15. Birthplace: Maryland

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 27, 1948 (month) (day) (year)

Cemetery or crematory: Mt Olivet Cemetery

Location: Frederick, Md

18. Funeral director: M. R. Etchison & Son

Address: 106 E. Church St

19. Nov 24 1948 (Date rec'd by registrar) C. Harry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24, 1948 at 3:15 A. M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from June 15, 1946, to Nov. 24, 1948 and that I last saw her alive on Nov. 23, 1948

Immediate cause of death	DURATION
Pulmonary tuberculosis	5 mos.
Due to	
Due to	
Other conditions: Schizophrenia, paranoid type	2 1/2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 11/24/48